STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495409	A. BUILDING _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABINGDON HEALTH CARE LLC	15051 HARMONY HILLS LANE ABINGDON, VA 24211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 12/04/18 through 12/06/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. The census in this 120 certified bed facility was 114 at the time of the survey. The survey sample consisted of 23 current Resident reviews and 3 closed record reviews .	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid certification survey was conducted 12/4/18 through 12/6/18. Complaints were investigated during the survey. Corrections are required for compliance with the following Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 114 at the time of the survey. The survey sample consisted of 24 current Resident reviews and 3 closed record reviews.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 583		1/18/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/21/2018

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F 583	Continued From page 1 §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, facility staff failed to provide personal privacy while providing care for 1 of 27 Residents in the survey sample (Resident #16). The findings included: The facility staff failed to provide privacy for Resident #16 while receiving ADL care in the shower room. Resident # 16 was a 97-year-old- female who was admitted to the facility on 4/13/16. Diagnoses included but were not limited to: dementia, major depressive disorder, anemia, and osteoarthritis.	F 583	F583 1. It is duly noted that the staff failed to provide privacy for Resident #16 while receiving ADL care in the shower room as outlined in the 2567. CNA #1 and #2 both were re-educated on 12/6/18 on personal privacy during patient care. 2. Any resident has the potential to be affected. 3. Re-education was initiated on 12/6/18 by the Director of Nursing and Unit Mangers with nursing staff addressing personal privacy while providing care to	

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F 583	Continued From page 2 The clinical record for resident # 16 was reviewed on 12/6/18 at 10:32 am. The most recent MDS (minimum data set) assessment for Resident # 16 was a quarterly assessment with an ARD (assessment reference date) of 11/21/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 16 had a BIMS (brief interview for mental status) score of 10 out of 15, which indicated that Resident # 16's cognitive status was moderately impaired. The plan of care for Resident # 16 was reviewed and revised on 10/9/18. The facility staff documented a focus area for Resident # 16 as, "Resident # 16 requires supervision-limited assistance with adls (activities of daily living) due to mobility, hx (history) of cva, (cerebrovascular accident) glaucoma. Her level of assistance varies r/t (related to) fatigue and weakness." Interventions included but were not limited to, "Assist with/provide ADL care as needed." On 12/05/18 at 10:46 am, a Resident council meeting was held with facility residents. During the resident council meeting, two alert and oriented residents expressed concerns about privacy and dignity while receiving care in the shower room on Martha's Ridge. On 12/06/18 at 9:28 am, the surveyor entered the shower room on Martha's Ridge. Upon entering the shower room, the surveyor observed 2 residents, Resident # 16 and Resident # 8, and 2 CNAs (certified nursing assistants). The surveyor observed that the privacy curtain in the shower room had not been pulled to provide privacy. The surveyor observed CNA # 1 assisting Resident #	F 583	residents. 4. The Unit Managers will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks, then monthly x2 months. These residents will be assessed to ensure personal privacy is provided during care. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings.	

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F 583	Continued From page 3	F 583		

16 near the commode area. Resident # 16 was visible to the surveyor, CNA # 2 and Resident # 8. Resident # 16 was observed sitting in a wheelchair. Resident # #16's upper body was clothed and the surveyor observed that Resident # 16 had on a brief that had been pulled up to the mid-thigh area. When CNA # 2 noticed that the surveyor had entered the room, CNA # 2 pulled the privacy curtain. The surveyor observed CNA # 1 roll Resident # 16 in the wheelchair toward the back of the shower room near the shower area. Resident # 16 was observed in an area where the privacy curtain had not been pulled and was visible to Resident # 8 while wearing a brief that had been pulled to the mid-thigh area. When CNA # 2 realized that the surveyor was watching she pulled the privacy curtain in front of Resident # 16.

On 12/06/18 at 9:47 am, the surveyor interviewed CNA # 2. The surveyor asked CNA # 2 if she was aware of the issue when the surveyor entered the shower room. CNA # 2 stated, "Yes, the shower room had not in use and I just rolled on in there with Resident # 8." "That's why I came out and switched the sign to in use." The surveyor asked CNA # 1 if she realized that Resident # 8 was able to see Resident # 16 in the wheelchair with a brief pulled to the mid-thigh area. CNA # 2 stated, "Yes, that's why I pulled that curtain." The surveyor asked CNA # 2 if she saw when CNA # 1 rolled Resident # 16 toward the back of the shower room to an area where Resident # 16 was again visible to Resident # 8 with a brief that had been pulled up to the mid-thigh area. CNA # 2 stated, "Yes, and I pulled the curtain but I couldn't get it to go the right way so I stood there and held it."

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F 583	Continued From page 4 On 12/06/18 at 10:18 am, the surveyor interviewed CNA # 1. Before the surveyor could ask CNA # 1 about the issues as stated above, CNA # 1 stopped the surveyor and stated, "I know the shower room." "I knew as soon as she rolled in there it was an issue." CNA # 1 agreed that the privacy curtains had not been pulled and Resident # 16 had been visible to Resident # 8 while wearing a brief that had been pulled up to the mid-thigh area. The facility policy on "Dignity and Respect" contained documentation that included but was not limited to: ..."Procedure 3. Cover the resident when providing care so only the necessarily exposed body part is visible to you." ... On 12/6/18 at 12:23 pm, the facility administrator was made aware of the findings as stated above. No further information was provided to the survey team prior to the exit conference on 12/6/18.	F 583		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved	F 622		1/18/19

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F 622	Continued From page 5	F 622		

sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is

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F 622	Continued From page 6 communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, the facility staff failed to provide a copy of the comprehensive care plan goals to the	F 622	F622 1. It is duly noted that the staff failed to provide a copy of the comprehensive care	

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F 622	Continued From page 7 receiving facility for 1 of 27 residents in the survey sample (Resident #61). The findings included: The facility staff failed to provide a copy of the comprehensive care plan goals to the receiving facility for Resident #61. Resident #61 was readmitted to the facility on 10/31/18 with the following diagnoses of, but not limited to coronary artery disease, heart failure, high blood pressure, diabetes, stroke, peripheral vascular disease, arthritis, and seizure disorder. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/7/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 3 out of a possible score of 15. Resident #61 was also coded as requiring extensive assistance of 2 or more staff members for dressing, personal hygiene and bathing. The surveyor performed a review of Resident #61's clinical record on 12/5/18. During this review, the surveyor noted that the resident was discharged on 10/23/18 to the hospital. There was no documentation in the clinical record that reflected a copy of the comprehensive care plan goals being given to the receiving facility. At 5:30 pm, surveyor notified the interim administrator, director of nursing and the corporate nurse of the above documented findings. The interim administrator stated, "We do not send the Comprehensive care plan goals when the resident is transferred out to the hospital."	F 622	plan goals to the receiving facility for Resident #61 as outlined in the 2567. Resident #61 had already been readmitted to facility prior to the end of survey. Therefore, we were unable to supply the receiving provider with the comprehensive care plan goals. 2. All residents have the potential to be affected if the comprehensive care plan goals are not sent to the receiving provider upon transfer/discharge. As of 12/6/18, any resident that is transferred/discharged will have the comprehensive care plan goals sent with them to the receiving provider. 3. Re-education was initiated on 12/6/18 by the Director of Nursing and Unit Managers with licensed staff addressing the requirement to send the comprehensive care plan goals to the receiving providers upon transfer/discharge. 4. The Unit Managers will audit any residents that are transferred/discharged weekly for four (4) consecutive weeks, then monthly x2 months to ensure the comprehensive care plan goals were sent to the receiving provider. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings.	

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F 622	Continued From page 8 No further information was provided to the surveyor prior to the exit conference on 12/6/18.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge,	F 623		1/18/19

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under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder

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F 623	Continued From page 10 established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, facility staff failed to provide a written notice of transfer to the resident or resident's representative for 1 of 27 residents in the survey sample (Resident #61). The findings included: The facility staff failed to provide a written notice of transfer to the resident or resident's representative for Resident #61. Resident #61 was readmitted to the facility on 10/31/18 with the following diagnoses of, but not limited to coronary artery disease, heart failure, high blood pressure, diabetes, stroke, peripheral vascular disease, arthritis, and seizure disorder.	F 623	F623 1. It is duly noted that the staff failed to provide a written notice of transfer to the resident or resident□s representative for Resident #61 as outlined in the 2567. Resident #61 had already been readmitted to the facility prior to the end of survey. 2. Any resident has the potential to be affected if a written notice of transfer is not sent when a resident is transferred to another facility. As of 12/6/18, any resident that is transferred will have a written notice of transfer sent to the appropriate individual.	

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F 623	Continued From page 11 On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/7/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 3 out of a possible score of 15. Resident #61 was also coded as requiring extensive assistance of 2 or more staff members for dressing, personal hygiene and bathing. The surveyor performed a review of Resident #61's clinical record on 12/5/18. During this review, the surveyor noted that the resident was discharged on 10/23/18 to the hospital. There was no documentation in the clinical record that reflected a written notice of transfer was given to the resident or resident's representative. At 5:30 pm, surveyor notified the interim administrator, director of nursing and the corporate nurse of the above documented findings. The interim administrator stated, "The nurses fill out the Enteract form but they do not give a copy of this to the resident." No further information was provided to the surveyor prior to the exit conference on 12/6/18.	F 623	3. Re-education was initiated on 12/6/18 by the Director of Nursing and Unit Managers with licensed staff addressing the requirement that a written notice of transfer be sent to the appropriate individual upon a residents transfer. 4. The Unit Managers will audit any residents that are transferred weekly for four (4) consecutive weeks, then monthly x2 months to ensure that a written notice of transfer was sent to the appropriate individual. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if	F 625		1/18/19

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ABINGDON HEALTH CARE LLC	15051 HARMONY HILLS LANE ABINGDON, VA 24211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 12 any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, facility staff failed to provide written information concerning bed hold policy to the resident or resident's representative for 1 of 27 residents in the survey sample (Resident #61). The findings included: The facility staff failed to provide a written notice to the resident or resident's representative concerning a bed hold for Resident #61. The resident was discharged from the facility due to being admitted to the hospital. Resident #61 was readmitted to the facility on 10/31/18 with the following diagnoses of, but not limited to coronary artery disease, heart failure, high blood pressure, diabetes, stroke, peripheral	F 625	F625 1. It is duly noted that the staff failed to provide a written notice to the resident or resident□s representative concerning a bed hold for Resident #61 as outlined in the 2567. Resident #61 had already been readmitted to the facility prior to the end of survey. 2. Any resident has the potential to be affected if a written notice to the resident or resident□s representative concerning a bed hold is not sent when a resident is transferred/discharged from the facility. As of 12/6/18, any resident that is transferred/discharged from the facility will have a written notice of bed hold sent to the appropriate individual.	

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F 625	Continued From page 13 vascular disease, arthritis, and seizure disorder. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/7/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 3 out of a possible score of 15. Resident #61 was also coded as requiring extensive assistance of 2 or more staff members for dressing, personal hygiene and bathing. The surveyor performed a review of Resident #61's clinical record on 12/5/18. During this review, the surveyor noted that the resident was discharged on 10/23/18 to the hospital. There was no documentation in the clinical record, which reflected a written notice concerning a bed hold being given to the resident or resident's representative. At 5:15 pm, the surveyor asked the admissions staff #1 if Resident #61 or resident's representative was provided with written information concerning a bed hold. The resident was discharged from the facility on 10/23/18. The admissions staff #1 stated,"I call the resident's representative and verbally tell them about a bed hold but I don't provide them with a written notice." At 5:30 pm, surveyor notified the interim administrator, director of nursing and the corporate nurse of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 12/6/18.	F 625	3. Re-education was initiated on 12/6/18 by the Director of Nursing and Administrator with the admissions department and licensed nurses on the requirement that a written notice of bed hold be sent to the appropriate individual upon a residents transfer/discharge. 4. The Director of Admissions will audit any residents that are transferred/discharged weekly for four (4) consecutive weeks, then monthly x2 months to ensure that a written notice of bed hold was sent to the appropriate individual. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		1/18/19

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F 641	Continued From page 14 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, facility staff failed to accurately code the resident's status for 1 of 27 residents in the survey sample (Resident #115). The findings included: Resident #115 was admitted to the facility on 9/14/18. There was an entry MDS (Minimum Data Set) completed when the resident was admitted to the facility on 9/14/18 and then the next MDS that was completed was dated 9/20/18 when the resident was discharged from the facility. During the closed record review, the surveyor noted a progress note that was dated and timed for 9/20/18 at 11:33 am that read in part, "Patient discharged home with son ..." The surveyor reviewed the discharged MDS with ARD (Assessment Reference Set) of 9/20/18. Under Section A2100, the MDS was coded that the resident was discharged to the hospital. On 12/06/18 at 10:26 am, the surveyor notified RN (registered nurse) #1 of the above documented findings. RN #1 stated, "I will go on there and get this corrected." The interim administrator, director of nursing and corporate nurse was notified of the above documented findings on 12/6/18 at 11 am.	F 641	F641 1. It is duly noted that the staff failed to accurately code the resident□s status for resident #115 as outlined in the 2567. Resident #115 MDS was corrected on 12/06/18. 2. All residents have the potential to be affected if facility staff fails to complete accurate MDS assessments. 3. Re-education was initiated on 12/6/18 by the Regional RAI Consultant with the MDS Director and MDS Coordinators on accuracy of MDS assessments in regards to the coding of section A item A2100 Discharge status. 4. The MDS Coordinator will complete a 100% audit of Resident□s discharge MDS Assessment that have discharged in the past 6 months. The audit will focus on accuracy of coding section A item A2100 coding of discharge status within the past 6 months with start date of audit to be 12/06/2018 and going forward will audit 10% of Discharge Resident□s MDS□s weekly x 4 weeks and then monthly x 2 to ensure Discharge Status in section A item A2100 are accurately coded based upon resident documentation. Any discrepancies will be addressed	

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F 641	Continued From page 15 No further information was provided to the surveyor prior to the exit conference on 12/6/18.	F 641	promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility record review, the facility staff failed to store medications in a secured, locked medication cart for 1 of 27 residents in the survey sample (Resident #60).	F 761	F761 1. It is duly noted that LPN #1 failed to store medications in a secured, locked medication cart for Resident #60 as outlined in the 2567. Medication was	1/18/19

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F 761	Continued From page 16 The findings included: Resident #60 was admitted to the facility on 8/28/18 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, diabetes and peripheral vascular disease. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/1/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #60 was also coded as requiring extensive assistance of 1 staff member for personal hygiene and being totally dependent on 1 staff member for bathing. During the medication administration observation on 12/6/18 at 8:45 am, the surveyor observed LPN (licensed practical nurse) #1 leaving Lasix 60 mg tablets on the top of the medication cart. LPN #1 walked completely in Resident #60's room and administered medications to the resident. The medication cart was left unattended by LPN #1. At approximately 9:05 am, the surveyor notified the interim administrator and the director of nursing of the above documented findings. The surveyor also requested the facility's policy on storage of medications. At 9:15 am, the interim administrator provided the surveyor with the facility's titled "Medication Administration". The policy read in part, " ...The medication cart should be kept locked at all times unless in use ..." The interim administrator stated to the surveyor, "This isn't very specific for the problem. But you are right, that's simple nursing and the medications should not be left on top of	F 761	immediately secured in med cart. LPN #1 was re-educated on 12/6/18 on the general guidelines for medication storage policy. 2. Any resident receiving medications have the potential to be affected. 3. Re-education was initiated on 12/6/18 by the Director of Nursing and Unit Managers with licensed staff addressing the facility policy regarding the proper storage and securing of medications. 4. The RN Supervisors will inspect all medication carts daily for two (2) weeks, then weekly for four (4) weeks, then monthly x2 months to ensure proper storage and securing of medications. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings.	

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F 761	Continued From page 17 the cart." No further information was provided to the surveyor prior to the exit conference on 12/6/18.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review it was determined the facility staff failed to prepare and store foods in a clean and sanitary manner. ~ Staff failed to securely close and date opened frozen foods that were returned to the freezer. ~ Staff failed to discard milk products after the "BEST BY" date on the carton had passed. Findings:	F 812	F812 1. (a) It is duly noted the staff failed to securely close and date opened frozen food that was returned to the freezer as outlined in the 2567. The frozen food was discarded. (b) It is duly noted the staff failed to discard milk products before the BEST BY date on the carton as outlined in the 2567.	1/18/19

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F 812	Continued From page 18 1. On 12/4/18 at 1:00 PM the facility kitchen was reviewed by two surveyors and the DM (dietary manager). The walk-in freezer was observed to contain an opened box of mixed frozen vegetables. The card board box was opened at the top and the food inside was in a plastic bag that was not sealed. The box had not been dated as to when the food had been opened. The DM was asked about the opened box of food and she told the surveyor it did not have to be resealed when it was in a freezer. The DM then reached into the box and tied and knot in the top of the plastic bag which effectively sealed the food from air. After failing to find a date on the box, the DM then turned around and asked a staff member when the food had been opened. She told the surveyor the food had just been opened the day prior. The freezer was also observed to have accumulated icicles hanging from a pipe in the rear wall for the freezer. Three packages of prepared meals were observed on the shelf next to the piping and had icicles hanging from the packaging. The DM pulled the food off the shelving and discarded it. She said the freezer had been fixed already--but the ice had not been cleaned from the piping since the maintenance manager had repaired it. The sugar and flour bins in the kitchen floor under and shelf were observed to have food debris and crumbs on the sliding lids. The sugar bin was observed to have some dark stains on the inside walls above the sugar. These stains appeared to have been splashed or otherwise smeared on the inside of the bin.	F 812	The milk was discarded immediately. 2. (a) Any resident has the potential to be affected if frozen food is not securely closed and dated when opened. (b) Any resident has the potential to be affected if milk is not discarded by the BEST BY date on the carton. 3. (a) Re-education was initiated on 12/4/18 by the Dietary Manager with dietary staff on securely closing and labeling date opened on frozen foods prior to returning them to the freezer. (b) Re-education was initiated on 12/6/18 by the Dietary Manager with dietary staff on discarding items by the BEST BY date. 4. (a) The Dietary Manager and weekend supervisor will inspect freezer daily for two (2) weeks, then weekly for four (4) weeks, then monthly x2 months to ensure proper storage and labeling of opened frozen foods returned to freezer. (b) The Dietary Manager and weekend supervisor will audit refrigerators in dining rooms on all units daily for two (2) weeks, then weekly for four (4) weeks, then monthly x2 months to ensure milk products have been discarded prior to the BEST BY date on the carton. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review	

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F 812	Continued From page 19 Facility staff removed the lids and cleaned the bins while the surveyor was on the initial tour of the kitchen. On 12/6/18 at 12:20 PM the surveyor received and reviewed the facility policy for Food and Supply Storage. It contained the following: "Opened frozen foods are securely closed and dated with a use by date of 3 months from the date opened." After reviewing this policy with the DM, she still maintained the food was "securely closed". The DM said the box had been dated prior to the surveyor's tour, but said she had to ask staff when the food had been opened just to "confirm" the date. The surveyor addressed the issue with the administrator, DON and CN (corporate nurse) prior to the survey exit. The surveyor noted the food in a freezer must be sealed against the air to prevent freezer burn, which would affect the flavor and the nutritional value of any food not properly stored. No additional information was provided prior to the survey team exit. 2. The facility staff failed to ensure that milk was discarded after the use by date on 1 of 3 units on the facility. On 12/06/18 at 10:00 am, the surveyor observed 4 cartons of strawberry milk with the date "Dec 01" in the unit refrigerator on the Art unit that was available for distribution. On 12/06/18 at 10:15 am, the surveyor showed	F 812	and further analysis of findings.	

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F 812	Continued From page 20	F 812		

the facility administrator the 4 cartons of strawberry milk dated "Dec 01" that had been observed in the unit refrigerator on the Art unit. The facility administrator observed the 4 cartons of strawberry milk and agreed that it was in the unit refrigerator past printed use by date.

On 12/06/18 at 10:38 am, the surveyor spoke with the dietary services manager and the director of nutrition services. The dietary services manager stated that the 4 cartons of strawberry milk had been discarded and she does not know where the 4 cartons of strawberry milk came from.

The facility policy on "Food and Supply Storage" contained documentation that included but was not limited to,
..." Refrigerated Foods
3. All dairy products whether opened or sealed, including milk, cottage cheese, and sour cream, must be used or discarded by the "use by" date specified by the manufacturer."

On 12/6/18 at 1:00 pm, the administrative team was made aware of the findings as stated above.

No further information was provided to the survey team prior to the exit conference on 12/6/18.
Based on observation, staff interview, and facility document review, facility staff failed to store food in a safe, clean manner.

FACILITY

Kitchen
12/04/18 01:15 PM Initial tour
Can opener cleaned
Per dietary manager stove is cleaned daily and as

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F 812	Continued From page 21	F 812		

needed. There is debris on the stove however staff is cleaning the kitchen following the lunch meal.
Hood is clean
Walk in temps collected appropriately
Freezer temps collected appropriately
Dry storage ok
12/04/18 04:40 PM Food arrives to Martha's Ridge dietary staff is observed sanitizing hands appropriately prior to handling food.
12/04/18 05:00 PM Tray line temps
String beans-182
vag lasagna-162
Chicken patty with gravy-184
Mashed potato-204
gravy-186
Broccoli-131 reheat 168
Pureed bread-178
Pureed string beans-178
pureed chicken patty with gravy-193
Pureed veg lasagna-179
peanut butter pie-47- put back in cooler 38
pudding-45 put back in cooler 40
12/06/18 10:00 AM Observed 4 cartons of Strawberry milk with the Date Dec 01 in the fridge on Unit 1 that was avaliable for distribution on art Unit.
12/06/18 10:15 AM Spoke with the facility administrator and showed her the milk and agreed that it was in the fridge past printed expiration date.
12/06/18 10:38 AM Kelly Brunicardi Unit Maniger and Director of nutrition services Marianne Ehrreich stated that they have been discarded and she does not know where it came from. Stated that she had to take 2 strawberry because there was none down there.